Florida Department of Health in Gulf County

2475 Garrison Avenue • Port St Joe, FL 32456• (850) 227-1276 • FAX (850) 227-1794
807 Highway 22 • Wewahitchka, FL 32465• (850) 639-2644 • FAX (850) 639-5934

FINANCIAL STATEMENT FOR FEE DETERMINATION

Name:_____ Birthdate:_____ Soc. Sec. Number:_____
Mailing Address:_____ City:_____ State:_____
Street Address:_____ City:_____ State:_____
Work Phone Number:_____ Home Phone Number:_____
Cell Phone Number:_____ Race (if multi-racial, please list):_____
Marital Status:_____ Veteran's Discharged: _____ Yes or _____ No
Ethnicity (check one): Hispanic_____ Non-Hispanic _____ Primary Language: _____
Do you have any cultural and/or religious beliefs that could affect your treatment? ____ Yes or ____ No
(If yes, please discuss with provider)

**********PLEASE READ CAREFULLY REGARDING YOUR FEE FOR SERVICES*********

Florida Department of Health Gulf County offers a **sliding fee scale**. If you choose to answer questions regarding your income, it will be used solely for sliding fee scale determination and you will be charged a fee for our services based on your family size and annual income. Please provide the below information to assist in determining your fee. You may request a review of the fee charge. You have the right to refuse to give financial information, thereby accepting a fee equal to the full cost of service.

I choose to pay full cost of service. Yes ____ No ____
Are you on Medicaid, Medicare, or private insurance? Yes ___ No ___
Name of Primary Insurance:_____ Name of Secondary Insurance:_____
Name of Dental Insurance: _____

INCOME FOR YOUR COMPLETE HOUSEHOLD OR FAMILY UNIT
List each family member in household and include **ALL** types of income (SSI, AFDC, child support, retirement, unemployment, etc.)

NAME	DATE OF BIRTH	FAMILY RELATION	PLACE OF EMPLOYMENT OR OTHER SOURCE OF INCOME	INCOME BEFORE DEDUCTION OR TAXES (PLEASE CIRCLE)
1.				$ WK MO
2.				$ WK MO
3.				$ WK MO
4.				$ WK MO
5.				$ WK MO

Do you pay out child care or support? Yes _____ No _____ How much monthly? _____

PLEASE READ CAREFULLY BEFORE SIGNING: I certify that the above information is true and correct to the best of my knowledge and belief. I know that I may be prosecuted under state law if I knowingly conceal or report wrong information. I give consent to the staff of Florida Department of Health in Gulf County to make inquiry and verify the information I have reported. I agree to report any change in gross income in excess of fifty dollars ($50) per month and any change in number of dependents. If I knowingly withhold or falsely misrepresent any information, I will be assessed at full cost of service.

Signature:_____ **Date**: _____

CONTACT PERSON IN CASE OF EMERGENCY:
Name of contact:_____ Relation:_____
Phone number of contact person: Home:_____ Work:_____

FLORIDA DEPARTMENT OF HEALTH

Dental Health History

Name _____
ID No. _____
Birth Date _____

In the following questions, circle **Yes** or **No**, whichever applies. Your answers will be considered confidential.

1. Do you **(PATIENT)** have or have you **(PATIENT)** had any of the following:

Rheumatic Fever or Heart Murmur	Yes	No	Neurological Problems	Yes	No
Heart Trouble or Shortness of Breath	Yes	No	Tuberculosis (TB) or Persistent Cough	Yes	No
High or Low Blood Pressure	Yes	No	Diabetes or Excessive Thirst	Yes	No
Fainting or Dizzy Spells	Yes	No	Epilepsy or Seizures	Yes	No
Stroke	Yes	No	Kidney Problems or Excessive Urination	Yes	No
Anemia or Blood Problems	Yes	No	Liver Problems or Hepatitis	Yes	No
Sickle Cell Anemia	Yes	No	Venereal Disease	Yes	No
Excessive Bleeding or Bruise Easily	Yes	No	AIDS/ARC/HIV Positive	Yes	No
Blood Transfusions	Yes	No	Cancer	Yes	No
Allergies or Skin Rash	Yes	No	Pregnancy	Yes	No
Asthma	Yes	No	Trimester 1 2 3		
Thyroid Problems	Yes	No	Painful or Swollen Joints	Yes	No
Emotional Problems	Yes	No	Other _____	Yes	No

2. Are you **(PATIENT)** currently under the care of a physician (doctor)? Yes No
   If yes, list name of doctor. _____

3. Have you **(PATIENT)** been hospitalized in the last 2 years? Yes No
   If yes, why? _____

4. Are you **(PATIENT)** currently taking any medications, pills or drugs? Yes No
   If yes, list. _____

5. Are you **(PATIENT)** allergic to or have you ever experienced any ill effect from a local anesthetic (novocain), penicillin, or any drugs/pills? i.e., rash, itching or fainting. Yes No
   If yes, describe. _____

6. Have you **(PATIENT)** ever experienced any unfavorable reaction from previous dental treatment? Yes No
   If yes, describe. _____

7. Are you **(PATIENT)** currently having any dental pain or problem? Yes No
   If yes, describe. _____

I certify that I have read and understand the above questions and have answered the questions to the best of my knowledge. I have asked for an explanation of any terms (words) that I did not know (if any), and my questions have been answered to my satisfaction. I will not hold my dentist, or any of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

I also understand that before treatment is provided, I have the right to have the benefits, alternatives, and significant risk factors associated with this treatment explained to my satisfaction.

Signature of Patient _____ Date _____
(If patient is a child, parent or legal guardian must sign) Relationship _____

Comments by Dentist: _____

_____

_____

Signature of Dentist _____ Date _____

DH 3117, 10/96 (Part 5) (Replaces HRS-H Form 3117, part 5, which may be used)
(Stock Number: 5744-005-3117-7)

Dental Health History Review/Update:

1. Comments:

Patient:_____

_____

Dentist:_____

Date _____ Patient's Signature _____ Dentist's Signature _____

2. Comments:

Patient:_____

_____

Dentist:_____

Date _____ Patient's Signature _____ Dentist's Signature _____

3. Comments:

Patient:_____

_____

Dentist:_____

Date _____ Patient's Signature _____ Dentist's Signature _____

4. Comments:

Patient:_____

_____

Dentist:_____

Date _____ Patient's Signature _____ Dentist's Signature _____

5. Comments:

Patient:_____

_____

Dentist:_____

Date _____ Patient's Signature _____ Dentist's Signature _____

6. Comments:

Patient:_____

_____

Dentist:_____

Date _____ Patient's Signature _____ Dentist's Signature _____

7. Comments:

Patient:_____

_____

Dentist:_____

Date _____ Patient's Signature _____ Dentist's Signature _____

8. Comments:

Patient:_____

_____

Dentist:_____

Date _____ Patient's Signature _____ Dentist's Signature _____

BROKEN APPOINTMENT & NO SHOW POLICY

The Florida Department of Health in Gulf County strives to service and improve the health of our patients. For us to be able to better serve and be more efficient for our patients we have established a Broken Appointment and No Show Policy.

Due to increasing number of broken appointments at the FDOH Gulf County and dental clinic sites, it is necessary to enforce a Broken Appointment/No Show Policy effective immediately.

It is the responsibility of the patient (or parent, in the case of a child) to notify the FDOH Gulf County or dental clinic at least 24 hours prior to their scheduled appointment if they will be unable to make their appointment. Appointments cancelled at least 3 hours before scheduled appointment will not be considered a No Show. If there are three or more No Shows or broken appointments without proper notice, the patient will not be offered pre-booked appointments for up to one year. The patient will be offered to come in and wait to be seen as a work in.

Every effort will be made to contact patients by phone or mail to remind them of their appointment a few days before it is scheduled. Monday appointments will be contacted on the Friday prior due to weekend closure. It is the responsibility of the patient to notify FDOH Gulf County or dental clinic of current contact information for this purpose.

By signing below, you acknowledge that you have read and understand the above statement and that every effort will be made to contact the FDOH Gulf County or dental clinics when you are unable to keep your appointment.

Signature: _____ Date: _____

Witness: _____ Date: _____

FLORIDA DEPARTMENT OF HEALTH

INITIATION OF SERVICES

PART I CLIENT-PROVIDER RELATIONSHIP CONSENT

Client Name: _____

Name of Agency: Florida Department of Health in Gulf County

Agency Address: 2475 Garrison Avenue, Port St Joe, FL 32456/ 807 Hwy 22, Wewahitchka, FL 32465

I consent to entering into a client-provider relationship. I authorize Department of Health staff and their representatives to render routine health care. I understand routine health care is confidential and voluntary and may involve medical office visits including obtaining medical history, examination, administration of medication, laboratory tests and/or minor procedures. I may discontinue the relationship at any time.

PART II DISCLOSURE OF INFORMATION CONSENT (treatment, payment or healthcare operations purposes only**)**

I consent to the use and disclosure of my medical information; including medical, dental, HIV/AIDS, STD, TB, substance abuse prevention, psychiatric/psychological, and case management; for treatment, payment and health care operations.

PART III MEDICARE PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE, AND PAYMENT REQUEST (Only applies to Medicare Clients)

As Client/Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release my medical information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the above named agency and authorize it to submit a claim to Medicare for payment.

PART IV ASSIGNMENT OF BENEFITS (Only applies to Third Party Payers)

As Client /Representative signed below, I assign to the above named agency all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. I am personally responsible for charges not covered by this assignment.

PART V MY SIGNATURE BELOW VERIFIES THE ABOVE INFORMATION AND RECEIPT OF THE NOTICE OF PRIVACY RIGHTS

_____ _____ _____

Client/Representative Signature | Self or Representative's Relationship to Client | Date

_____ _____

Witness (optional) | Date

PART VI WITHDRAWAL OF CONSENT

I, _____ WITHDRAW THIS CONSENT, effective _____

Client/Representative Signature | Date

_____ _____

Witness (optional) | Date

Client Name: _____

ID#: _____

DH 3204, [Approved November 2008], Original to file Copy to client DOB: _____

PARENT/GUARDIAN'S RESPONSIBILITY IN OBTAINING DENTAL TREATMENT FOR A MINOR CHILD

Please initial that you have read and understand each statement.

_____1) If a child is to be brought to an appointment by someone other than the natural parent or guardian, a signed and notarized "Transfer of Authority to Obtain Medical Treatment for a Minor Child" form must be on file in the child's file.

_____2) Guardians must provide a copy of the court order, signed by the judge, for the child's file. Changes must be reported and documentation provided promptly.

_____3) Children's medical histories must be updated every six months. If a caregiver other than the parent or guardian brings the child to their appointment they **must** provide a written, signed statement from the custodial party listing current medications and any changes to the child's health status since their last visit.

_____4) A care plan for future treatment, and associated costs, is explained to the accompanying adult at the end of each visit. **It is the parent or guardian's responsibility to obtain the information from them.** Any questions and/or requests for copies of documentation such as treatment plans should be addressed through the dental clinic front desk.

_____5) For children receiving dental treatment under the age of 18 it is **required** that the responsible adult remain on the premises in the waiting room to be available for the entire appointment

These conditions must be met for the minor child to receive treatment.

Signature _____ Print Name _____

Date _____

TRANSFER OF AUTHORITY TO OBTAIN DENTAL TREATMENT FOR A MINOR CHILD

I, _____, the Parent (Driver's License must be provided today)

of _____, a minor child, duly authorize the Florida Department of Health in Gulf County Dental Clinic staff to perform any routine or emergency dental procedure in my absence if escorted by one of the below family members.

The following individuals have my permission to escort said child to dental appointments, to approve, to discuss and to sign documents pertaining to the treatment and care of the child:

Name	Relationship to Child (Circle One)
_____	Stepparent – Grandparent – Adult Brother/Sister – Adult Aunt/Uncle
_____	Stepparent – Grandparent – Adult Brother/Sister – Adult Aunt/Uncle
_____	Stepparent – Grandparent – Adult Brother/Sister – Adult Aunt/Uncle
_____	Stepparent – Grandparent – Adult Brother/Sister – Adult Aunt/Uncle

The individual listed above must provide a Drivers License when bringing in minor child.

Signature _____ Print Name _____

Date_____

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

INFORMATION MAY BE DISCLOSED BY:

Person/Facility: _____ **Phone #:** _____

Address: _____ **Fax #:**_____

INFORMATION MAY BE DISCLOSED TO:

Person/Facility: Florida Department of Health in Gulf County **Phone #:** (850)227-1276 or 639-2644

Address: 2475 Garrison Avenue, Port St Joe, FL 32456 or 807 Highway 22, Wewahitcka, FL 32465 **Fax #:** (850)227-1794 or 639-2357

Other method of communication: _____

INFORMATION TO BE DISCLOSED: (Initial Selection)

_____ General Medical Record(s), including STD and TB _____ Progress Notes _____ History and Physical Results

_____ Immunizations _____ Family Planning _____ Prenatal Records _____ Consultations

_____ Diagnostic Test Reports (Specify Type of test(s)) _____

_____ Other: (specify) _____

I specifically authorize release of information relating to: (initial selection)

_____HIV test results for non-treatment purposes _____Substance Abuse Service Provider Client Records

_____Psychiatric, Psychological or Psychotherapeutic notes _____Early Intervention _____WIC

PURPOSE OF DISCLOSURE:

_____ Continuity of Care _____ Personal Use _____ Other (specify)_____

EXPIRATION DATE: This authorization will expire (insert date or event) _____. I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

REDISCLOSURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

REVOCATION: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.

_____ _____

Client/Representative Signature Date

_____ _____

Printed Name Representative's Relationship to Client

_____ _____

Witness (optional) Date

Client Name: _____

ID#: _____

DOB: _____